ROCK COUNTY HUMAN SERVICES DEPARTMENT Client # _____

CONFIDENTIAL INFORMATION RELEASE AUTHORIZATION – HSD THIRD PARTY REQUESTS

Client Name (include other names used)	DOB

1 Info. From (Individual/ Agency Making Disclosure)

- ☐ Rock County Human Services Dept.; Program or Division: _____
  - ☐ P.O. Box 1649, Janesville, WI 53547
  - ☐ 64 Eclipse Ctr., Beloit, WI 53511
  - ☐ 303 W. Court St., Janesville, WI 53548
  - ☐ 1900 Center Ave., Janesville, WI 53546
  - ☐ 113 S. Franklin Street, Janesville, WI 53545
- ☐ Other Individual/Agency (Enter name and address)

_____

2 Information To (Recipient of Information)

- ☐ Rock County Human Services Dept.; Program or Division: _____
  - ☐ P.O. Box 1649, Janesville, WI 53547
  - ☐ 64 Eclipse Ctr., Beloit, WI 53511
  - ☐ 303 W. Court St., Janesville, WI 53548
  - ☐ 1900 Center Ave., Janesville, WI 53546
  - ☐ 113 S. Franklin Street, Janesville, WI 53545
- ☐ Beloit Memorial Hospital, 1969 West Hart Road, Beloit, WI 53511
- ☐ Mercy Health System, 1000 Mineral Point, Janesville, WI 53545
- ☐ Rock County Sheriff's Office, 200 Highway 14 East, Janesville, WI 53545
- ☐ Social Security Administration, Disability Determination Bureau
- ☐ UW Hospital & Clinics, Madison, WI
- ☐ Other Individual/Agency (Enter name and address) _____

_____

3 Two-Way Exchange

I authorize this information to be released **between** the designated organizations (mark one).

☐ Yes ☐ No

4 Purpose/ Reason

- ☐ Benefit Determination
- ☐ Child Custody Case
- ☐ Coordinate Care and Services
- ☐ Disability Determination
- ☐ Driver's License Determination
- ☐ Insurance Claim
- ☐ Provider Licensing/Certifying
- ☐ Other _____

5 Specific Information to be Released

- ☐ Substance abuse records including screening, assessment, diagnoses, treatment plan and recommendations, ASAM, and Discharge Summary. ☐ Drug Test Results
- ☐ Mental health, psychiatric services, developmental disability records
- ☐ Child Protective Services Records
- ☐ Juvenile Justice Records
- ☐ Economic Support Services Records
- ☐ Including re-disclosure of (describe type of records) _____ from (name of treatment facility/other agency) _____ in our possession.
- ☐ Physical or general health records to include **AIDS** testing results.
- ☐ School records, teacher/counselor comments, academic progress, testing, M-Team reports, I.E.P., and transcripts.
- ☐ Other (Describe/specify) _____

6 Revocation & Expiration of Consent

I understand that this consent can be withdrawn by me in writing at any time except to the extent that action has already been taken in reliance thereon. To revoke authorization, please contact the Individual/Agency Making Disclosure (listed in section 1 above AND/OR section 2 when section 3 is marked Yes). If Rock County Human Services Department, please speak with your case manager or call the Medical Records Department at 608-757-5448. Unless revoked earlier, or otherwise specified below, this consent will expire in twelve (12) months from the date signed. If desired, specify another expiration date. ____/____/____

I hereby consent to and authorize the release of information as described on this form. I may also receive a copy of this consent form. The client or person authorized has a right to inspect and, upon payment of usual fee, receive a copy of the material to be disclosed. I understand that I am under no obligation to sign this form and that treatment will not be denied if I refuse to sign this authorization. WI Statutes 51.30 and 252.15 require patient authorization to disclose health information for payment purposes. **The recipient of the records may re-disclose the information that I authorize to be released only if allowed by law.** Records may be released from the signature date of this authorization forward, until the expiration of this authorization. I understand that information disclosed as a result of this authorization may no longer be subject to protection by federal privacy standards.

Client Signature	Date
Person Authorized by Client	Relationship to Client
Witness Signature	